LAST NAME

FIRST NAME **MIDDLE NAME**

GUARDIAN NAME (For Children Under 18**)**

ADDRESS

CITY **STATE** **ZIP CODE**

Sex (M) (F) **Telephone Number ( )**

DATE OF BIRTH
Jan Feb Mar Apr
May Jun July Aug
Sep Oct Nov Dec
(month-circle one) _____ _____
(day) (year)

Social Security Number

HISPANIC OR LATINO Yes No

COUNTRY OF BIRTH

TB Clinic Registration
For Office Use Only
PPD_____
CXR _____
Referral ☐ Y ☐ N
Need a Refill ☐ Y ☐ N
First time in Clinic ☐ Y ☐ N
Health Care Worker _____
Immigration _____
School _____
Shelter _____
Work _____
Nurses # _____
Med/Manager # _____
Insurance ☐ Y ☐ N
Care Source
Medicare
Medicaid

PRIMARY LANGUAGE

Do you smoke? (Yes) (No)
Does anyone in the house smoke? (Yes) (No)

Highest Grade Completed in School (circle one)
Grade School 1 2 3 4 5 6 7 8
High School 9 10 11 12
College 1 2 3 4
Post-Grad Studies ☐

RACE (please circle one or more races to show what you consider yourself to be)
White
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian or other Pacific Islander
Other (Specify)_____

Do you have a Tribal/Clan Affiliation? (Yes) (No)
Tribe/Clan Name _____

Insurance Information: Insurance Company Name _____Policy # _____

If **No** insurance what is your income per household? Yearly $____ Hourly $____ Number of persons in house _____
Do you have documentation of a previous positive skin test? (Yes) (No)

Location Risk Factors: Please check Yes or No if any of the following have ever applied to you.

Y	N	
( )	( )	Have you ever been homeless or are you currently staying in a homeless shelter?
( )	( )	Health Care Worker
( )	( )	Abused alcohol or drugs
( )	( )	Lived or worked in a residential institution (other than a jail or prison)
( )	( )	Lived or worked at a jail or prison

Medical Risk Factors: Please check Yes or No if you have ever had:

( )	( )	Diabetes
( )	( )	Cancer
( )	( )	Permanent kidney damage (chronic renal failure or insufficiency)
( )	( )	Hepatitis
( )	( )	Silicosis
( )	( )	Surgical removal of part of your stomach or intestines (starvation or malnutrition)

Have you been in close contact with someone who was sick with active TB disease? (Yes) (No)
Who was that person?_____
Have you been in close contact with someone with a positive skin test? (Yes) (No)
Who was that person?_____
Have you started TB medicine but did not finish it? (Yes) (No)
When and where did you take the medicine? _____